TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
KEVIN A. WILLIAMS, MD

Respondent Name
OLD REPUBLIC INSURANCE CO

MFDR Tracking Number
M4-17-2450-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
APRIL 13, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: Position summary not included in the dispute packet.

Amount in Dispute: $1,700.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Code 99203-25 was denied with No significant separately identifiable Evaluation and Management service has been documented. Modifier 25 is for a significant separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service…The provider was paid for CPT 20610, for the injection of L shoulder, and therefore the visit is included in the global period of CPT 20610…challenging non-payment of CPT 23405. This code was not billed. See attached appeal documents provided submitted and dated 3/21/17. Provider submitted code change from CPT 29999 to 23406. Denied as this charge was not reflected in the report as one of the procedures/services performed. (X133). Documented procedure is arthroscopic biceps tenotomy. 23405 and 23406 are open procedures."

Response Submitted by: Liberty Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 31, 2016	CPT Code 99203-25-57 Office Visit	$200.00	$0.00
February 7, 2017	CPT Code 23405	$1,500.00	Not eligible for review
TOTAL		$1,700.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets the fee guidelines for professional services.
3. 28 Texas Administrative Code §133.240 sets out the procedure for medical bill processing and audit by the insurance carrier.
4. 28 Texas Administrative Code §133.250 sets out the procedure for reconsideration for payment of medical bills.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - X212-This procedure is included in another procedure performed on this date.
   - 193, W3-The charge for this procedure exceeds the fee schedule allowance.
   - U301, 18-This item has been reviewed on a previously submitted bill, or is currently in process. Notification of decision has been previously proceed or will be issued upon completion of our review.

Issues

1. Is the August 31, 2016 office visit (CPT code 99203-25-57) included in the global surgery package of CPT code 20610?

2. Is Code 23405 eligible for dispute resolution per 28 Texas Administrative Code §133.307?

Findings

1. The insurance carrier denied reimbursement for the office visit, CPT code 99203-25-57, based upon reason code "X212-This procedure is included in another procedure performed on this date."

   On the disputed date of service, the requestor billed codes 20610-LT, 99203-25-57, J1040, and J2001. The respondent contends that reimbursement is not due because the requestor did not support billing for an office visit in conjunction with procedure code 20610-LT.

   28 Texas Administrative Code §134.203(a)(5) states, "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   Codes 99203 and 20610 are defined as:

   a. CPT code 99203 as "Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.."

   The requestor appended modifiers 25 and 57 that are defined as:

   - 25- "Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service."
   - 57- "Decision for Surgery."

   b. CPT code 20610 as "Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance."

   The requestor appended modifier LT-"Left Side" to code 20610.

Is the provider's billing of modifier "57" supported?

Per Medicare Claims Processing Manual, Chapter 12, (40.2)(A), Billing Requirements for Global Surgery:

> To ensure the proper identification of services that are, or are not, included in the global package, the following procedures apply.
>
> **A. Procedure Codes and Modifiers**
>
> Use of the modifiers in this section apply to both major procedures with a 90-day postoperative period and minor procedures with a 10-day postoperative period (and/or a zero day postoperative period in the case of modifiers "-22" and "-25").

CPT code 20610 has a 0-day postoperative period; therefore, per *Medicare Claims Processing Manual*, Chapter 12, (40.2)(A), it is categorized as a minor procedure.

The Medicare policy regarding modifier "57" is found at *Medicare Claims Processing Manual, Chapter 12, (40.2)(A)(4), Billing Requirements for Global Surgery* which states*:*

Evaluation and Management Service Resulting in the Initial Decision to Perform Surgery

> on the day before major surgery or on the day of major surgery that result in the initial decision to perform the surgery are not included in the global surgery payment for the major surgery and, therefore, may be billed and paid separately.
> In addition to the CPT evaluation and management code, modifier "-57" (decision for surgery) is used to identify a visit which results in the initial decision to perform surgery. (Modifier "-QI" was used for dates of service prior to January 1, 1994.)
> If evaluation and management services occur on the day of surgery, the physician bills using modifier "-57," not "-25." The "-57" modifier is not used with minor surgeries because the global period for minor surgeries does not include the day prior to the surgery. Moreover, where the decision to perform the minor procedure is typically done immediately before the service, it is considered a routine preoperative service and a visit or consultation is not billed in addition to the procedure.

Because code 20610 is considered a minor surgery, per *Medicare Claims Processing Manual*, Chapter 12, (40.2)(A)(4), the "The "-57" modifier is not used with minor surgeries because the global period for minor surgeries does not include the day prior to the surgery. Moreover, where the decision to perform the minor procedure is typically done immediately before the service, it is considered a routine preoperative service and a visit or consultation is not billed in addition to the procedure." The division finds the requestor did not support billing modifier 57 with the office visit.

Is the provider's billing of modifier "25" supported?

Medicare Claims Processing Manual, Chapter 12, (40.2)(A)(8), Billing Requirements for Global Surgery states:

> Significant Evaluation and Management on the Day of a Procedure
> Modifier "-25" is used to facilitate billing of evaluation and management services on the day of a procedure for which separate payment may be made. It is used to report a significant, separately identifiable evaluation and management service by same physician on the day of a procedure. The physician may need to indicate that on the day a procedure or service that is identified with a CPT code was performed, the patient's condition required a significant, separately identifiable evaluation and management service above and beyond the usual preoperative and postoperative care associated with the procedure or service that was performed. This circumstance may be
> reported by adding the modifier "-25" to the appropriate level of evaluation and management service.

A review of the submitted medical report finds that the requestor did not support "a significant, separately identifiable evaluation and management service above and beyond the usual preoperative and postoperative care associated with the procedure or service that was performed." Therefore, the Division finds that the disputed office visit is global to code 20610. As a result, reimbursement is not recommended.

2. On the Table of Disputed Services, the requestor is seeking dispute resolution for CPT code 23405.

   28 Texas Administrative Code §133.307(G) states "If the respondent did not receive the health care provider's disputed billing or the employee's reimbursement request relevant to the dispute prior to the request, the respondent shall include that information in a written statement." The respondent wrote "This code was not billed. See attached appeal documents provided submitted and dated 3/21/17. Provider submitted code change from CPT 29999 to 23406."

   28 Texas Administrative Code §133.240(i) states "If dissatisfied with the insurance carrier's final action, the health care provider may request reconsideration of the bill in accordance with §133.250 of this title."

   28 Texas Administrative Code §133.250(a) states "If the health care provider is dissatisfied with the insurance carrier's final action on a medical bill, the health care provider may request that the insurance carrier reconsider its action. If the health care provider is requesting reconsideration of a bill denied based on an adverse determination, the request for reconsideration constitutes an appeal for the purposes of §19.2011 of this title (relating to Written Procedures for Appeal of Adverse Determinations) and may be submitted orally or in writing."
   28 Texas Administrative Code §133.250(d) states "A written request for reconsideration shall:
   (1) reference the original bill and include the same billing codes, date(s) of service, and dollar amounts as the original bill;
   (2) include a copy of the original explanation of benefits, if received, or documentation that a request for an explanation of benefits was submitted to the insurance carrier;
   (3) include any necessary and related documentation not submitted with the original medical bill to support the health care provider's position; and

   (4) include a bill-specific, substantive explanation in accordance with §133.3 of this title (relating to Communication Between Health Care Providers and Insurance Carriers) that provides a rational basis to modify the previous denial or payment."

   28 Texas Administrative Code §133.250(i) states "If the health care provider is dissatisfied with the insurance carrier's final action on a medical bill after reconsideration, the health care provider may request medical dispute resolution in accordance with the provisions of Chapter 133, Subchapter D of this title (relating to Dispute of Medical Bills)."
   28 Texas Administrative Code §133.307(J) requires the requestor to submit "a paper copy of all medical bill(s) related to the dispute, as originally submitted to the insurance carrier in accordance with this chapter and a paper copy of all medical bill(s) submitted to the insurance carrier for an appeal in accordance with §133.250 of this chapter (relating to General Medical Provisions)."

   28 Texas Administrative Code §133.307(K) requires the requestor to submit "a paper copy of each explanation of benefits (EOB) related to the dispute as originally submitted to the health care provider in accordance with this chapter or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB.''

   The division reviewed the submitted documentation and finds:

   - The requestor originally billed code 29999.
   - The requestor submitted a bill marked "Corrected Claim" that lists code 23406 instead of code 29999.
   - A third bill lists code 23405 instead of code 23406.
   - No explanation of benefits were submitted for code 23405.
   - No proof that the bill for code 23405 was submitted to the insurance carrier for bill processing or reconsideration.

The division finds that the requestor did not support that code 23405 is eligible for medical fee dispute resolution per 28 Texas Administrative Code §133.250 and §133.307; therefore, it will not be considered further.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		04/28/2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.